

YOUTH VIOLENCE

Our nation's future is in the hands of our youth, for today's young people will become tomorrow's leaders. But violence threatens that future because of its tremendous impact on the health and well-being of our youth.

The Scope of the Problem

In the early 1980s, CDC recognized youth violence as a serious public health problem in the U.S. Scientific studies were begun to characterize the problem of violence and to determine how to prevent it. One of CDC's first findings was that violence affects young people in two ways: as victims and as perpetrators.

Youth as Victims of Violence

- Violence is a major cause of death. Homicide is the second leading cause of death among 15- to 24-year-olds.
- Violence is more prevalent in certain populations. Among 15- to 24-year-olds, homicide is the number one cause of death for blacks, the second leading cause of death for Hispanics, and the third leading cause of death for Native Americans.
- More than one-third of homicide victims are young people. In 1997, homicide ended the lives of 19,491 people in the United States—31% were 15 to 24 years old. On an average day in 1997, 17 young people were murdered.
- Most young victims were killed with guns. In 1997, 85% of homicide victims 15 to 19 years old were killed with firearms. The firearm homicide rate increased by 67% between 1987 and 1997 among 15- to 19-year-olds.



- America is number one in youth homicides. Homicide rates for young people in the United States are the highest in the world. For males 15 to 24 years old, the U.S. rate is 10 times higher than the rate in Canada, 15 times higher than in Australia, and 28 times higher than in France or Germany.
- Youth violence is responsible for many nonfatal injuries and disabilities. Violence is a leading cause of nonfatal injuries among young people. In 1995, almost 400,000 15- to 19-year-olds went to emergency departments because of interpersonal violence.
- Young people are safe in school. Violent death in schools is rare. Nationally, there are about 52 violent deaths a year in schools—less than 1% of all violent deaths occurring among school-age youth.
- In recent years, the homicide rate has fallen significantly. Among 15- to 19-year-olds, homicide rates declined from a high of 20.4 per 100,000 in 1993 to 13.6 per 100,000 in 1997. For the general population, the age-adjusted homicide rate declined from 10.6 per 100,000 in 1993 to 7.9 per 100,000 in 1997.

Youth as Perpetrators of Violence

- Young people instigate one-fifth of the violence in America. Nearly 20% of the people arrested for violent crimes in 1994 were younger than 18 years old.
- Murderers are getting younger. The number of young people arrested on homicide charges rose dramatically between 1989 and 1994. During this period, arrest rates for teenagers 14 to 17 years old rose 41%, and rates climbed 18% for youths ages 18 to 24. During the same period, homicide arrest rates for adults 25 and older declined 19%.
- The level of nonfatal violence is substantially higher for 15- to 24-year-olds than for any other age group. Of 22,133 suspects arrested for rape, 37% were ages 15 to 24. Of 94,034 suspects arrested for robbery and 372,422 arrested for aggravated assault, 57% and 34% respectively were 15 to 24 years old.

Working toward a Solution

Youth violence is a complex issue that goes to the heart of our social system and even to the family structure. In seeking solutions to the problem, NCIPC follows the four steps of the public health approach.

Describing and monitoring trends in homicide and violent behavior and the magnitude of the problem is the first step in understanding and addressing the issue. NCIPC analyzes and reports findings on deaths and injuries resulting from violence. NCIPC also supports development of surveillance systems that provide a better understanding of violence-related injury and risk factors.

- In light of recent school shootings, NCIPC is working with the Department of Education (DOE) to conduct a second national study to determine if there has been a significant rise in school-associated violent deaths. The first such national study, conducted jointly by NCIPC and DOE, examined the period 1992 to 1994.

- The Boston Pediatric Emergency Department Injury Surveillance Project is collecting data on every 3- to 18-year-old child treated in a Boston emergency department for a violence-related injury. The data are being used to estimate the cost of such injuries to the health-care system by hospital, residence, age and sex of patient, means of injury, and type of injury. These data will aid in developing and monitoring primary and secondary injury-prevention efforts that will target the costliest injuries.

The next step in finding solutions to youth violence is identifying risk factors that increase the likelihood of experiencing violence (as a victim or a perpetrator) as well as protective factors (they reduce a person's chance of becoming a victim or a perpetrator). NCIPC-supported research suggests that children who have good social and communication skills, learn the basics of resolving conflicts nonviolently, and receive emotional support from parents or other adults are less likely to behave violently than children without these advantages.

- At Columbia University, a study of lethal and non-lethal violence among teens is being conducted. The researchers have three aims: 1) to specify and test theoretical models based on social isolation and poverty to determine risk factors for adolescent homicide for 1976 to 1994 in U.S. cities; 2) to adjust and apply a conceptual model for homicide and hospitalized injury cases in New York City for 1988 to 1994; and 3) to conduct case studies in neighborhoods to identify the characteristics of areas in which rates of teen violence rise, fall, or remain stable. Study results have indicated that homicides are "contagious" under conditions such as concentrated poverty and weak family structure.
- In a study being conducted at the University of Illinois at Chicago, researchers are studying risk factors for serious antisocial and violent behavior among inner-city teenage boys, their families, and their partners. Over 24% of interviews with the boys were conducted in jail. Participants were interviewed on a number of topics, including hopes and expectations, family relationships, and criminal activity.

Study findings include 1) the varying patterns of development toward delinquency; 2) how family and peer factors thought to predict delinquency may depend on the community in which the teen grows up; and 3) the relationship of delinquency and violence to other behaviors such as unprotected sex and multiple partners.

The third step is developing and evaluating interventions to prevent violence. To determine how to prevent young people from becoming victims or perpetrators of violence, NCIPC has funded several projects across the country that are looking at a broad range of promising interventions. Some of these projects target young children and families to prevent the onset of known risk factors for later aggression and violence:

- One project examines the effectiveness of family intervention and school-based programs in reducing the risk for the early onset of aggression among children and for later adverse outcomes such as delinquency, failing school, and substance abuse.
- Two projects test interventions in child-care settings; the interventions are designed to create positive social environments for young children and their families. In one project, early-childhood workers are taught how to foster child development and to teach parents nonviolent behavioral patterns. The other project provides home visits to strengthen parenting skills among at-risk families and also targets the child-care-center environment to reduce the early onset of aggression and problem behavior among children.
- Another project teaches parents in prisons or jails about parenting skills, child development, anger control, and conflict resolution.

Other projects target adolescents who are at high risk for violence or for exhibiting violent behavioral patterns:

- One project targets youths treated in emergency departments for injuries sustained during an intentional assault. The goal is to reduce re-injury rates among young people by having the hospitals that treat them also refer them to agencies that serve youths.
- Two projects target youths attending alternative schools because they have been suspended or expelled from other schools for serious violent behavior, disruptive behavior, or substance abuse violations. These projects usually include training in social and communication skills, intercultural training, and programs to develop bonding with the community.
- The newest NCIPC evaluation project is an innovative, multisite evaluation of a state-of-the-art violence prevention protocol for middle schools. Four sites (in Durham, North Carolina; Richmond, Virginia; Chicago, Illinois; and Athens, Georgia) are collaborating with NCIPC scientists to develop and implement the protocol and to conduct rigorous, scientific evaluation.

The final step is disseminating information about effective violence prevention programs. To help researchers and prevention specialists conduct risk- and protective-factor research and to evaluate youth-violence-prevention programs, NCIPC published *Measuring Violence-Related Attitudes, Beliefs, and Behaviors: A Compendium of Assessment Tools*. The compendium includes questions, scales, and instruments for measuring attitudinal, psychosocial, behavioral, and environmental factors related to violence.

- NCIPC has developed a source book on the most promising approaches to implementing prevention programs aimed at reducing aggression and violence among youths. Four strategies have been selected for inclusion in the source book: social cognitive programs, mentoring programs, parent/family intervention programs, and home visits by a nurse. The source book builds upon the lessons learned from the first evaluation projects funded by NCIPC and draws upon the expertise of over 100 of the nation's leading scientists and practitioners as well as the scientific literature on youth-violence prevention. Publication is expected early in the year 2000.

Tony C., a high school junior who loved athletics, was 16 years old when another 16-year-old shot and killed him. Tony's mother says, "The motive for the shooting was an argument over a girl who was paying more attention to Tony. While I have always worried about the safety of my young African-American son, never in my wildest imaginings did I ever think that he would die as a result of a gunshot wound to the head. Everyone ran after it happened and left Tony there to die alone. It's a tragedy that has left a hole in our lives, shaken the foundations of our faith, and heaped unspeakable grief upon a nuclear and extended family who love him."

SUICIDE AND SUICIDAL BEHAVIOR

Injury due to suicidal behavior is a major public health problem in the United States. Suicide has ranked among the 10 leading causes of death in this country since 1975—but it can be prevented. While much has been learned about the factors that play a part in suicidal behavior, more research and prevention efforts are needed.

National strategies for preventing suicidal behavior must be developed and implemented to prevent the suffering and loss of life associated with such behavior. This effort requires the commitment and expertise of a broad spectrum of partners, from community leaders to public health professionals to suicide survivors to experts in mental health and substance abuse.

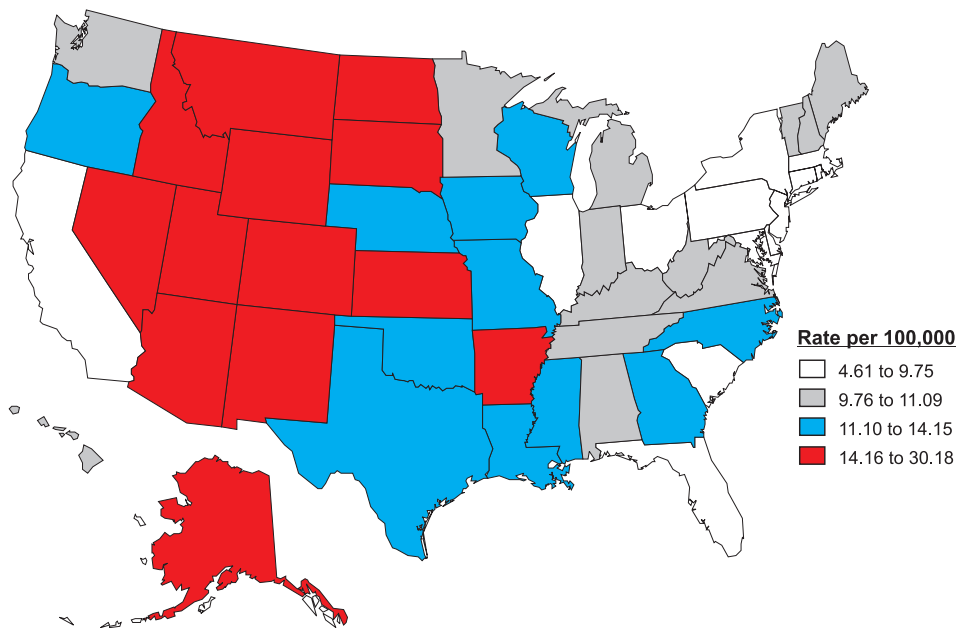
Working closely with states and communities, NCIPC makes five important contributions to understanding and preventing suicide:

- ♦ Evaluating and demonstrating ways to prevent suicidal behavior
- ♦ Describing and tracking such behavior
- ♦ Increasing knowledge of the causes and consequences of suicidal behavior
- ♦ Communicating scientific information about suicide prevention
- ♦ Coordinating a wide array of suicide-prevention programs

The Scope of the Problem

- More people die from suicide than from homicide in the United States. In 1997, 30,535 Americans took their own lives. In contrast, 19,491 were homicide victims. On average, 84 Americans commit suicide each day, and there have been more suicides than homicides each year since 1950. In 1997, suicide was the eighth leading cause of death in this country. It was the fourth leading cause of death among 25- to 44-year-olds.
- Suicide is a serious problem among young people. Between 1980 and 1997, the rate of suicide increased 109% for 10- to 14-year-olds and 11% for 15- to 19-year-olds. Suicide was the third leading cause of death for 15- to 24-year-olds in 1997. That same year, a nationwide survey of high school students found that in the previous year, one-fifth had seriously considered suicide and 1 in 13 had attempted it.
- Suicide rates are especially high among older adults (age 65 and older). Older adults have had the highest suicide rate of all age groups since 1933, the year all states began reporting deaths. Suicide rates tend to rise with age and are highest among white men age 65 and older. Older adults account for almost 20% of suicide deaths, but only 13% of the U.S. population. Older adults also make fewer attempts per completed suicide and have a higher male-to-female ratio of suicides than other groups.
- Most suicides are males. In 1997, males accounted for 80% of all suicides in the United States. Among 15- to 19-year-olds, boys were five times as likely as girls to commit suicide; among 20- to 24-year-olds, males were seven times as likely to commit suicide as females. Although more females attempt suicide than males, males are at least four times as likely to die from suicide.

Suicide Rates Among Persons Aged 15–19 Years United States, 1993–1997



- Suicide is only part of the problem of self-directed violence. The number of completed suicides reflects only a small portion of the impact of suicidal behavior. It is estimated that more people are hospitalized because of suicide attempts than are fatally injured. And, compared with the number hospitalized, an even greater number of people who attempt suicide are treated in outpatient settings or not at all. In 1997, an estimated 610,000 visits to U.S. hospital emergency departments were due to self-directed violence. In 1994, an estimated 10.5 million adults (about 6% of the adult population in the U.S.) reported having seriously considered suicide during the previous year.
- Suicide affects many populations. From 1979 to 1992, suicide rates for Native Americans were 1.5 times the national rates. Young men ages 15 to 24 accounted for 64% of all suicides among Native Americans (which includes American Indians and Native Alaskans). Suicide rates are higher than the national average for some groups of Asian Americans/Pacific Islanders (AAPIs). In Hawaii, the suicide rate for AAPIs is 4% higher than the rate for the rest of the population.

Asian-American women have the highest suicide rate among women age 65 or older. The suicide rate among young people is highest for white males. However, from 1980 to 1996, the suicide rate increased most rapidly among black males ages 15 to 19, more than doubling from 3.6 to 8.1 per 100,000. A 1997 survey of high school students found that Hispanic students (11%) were significantly more likely than white students (6%) to have reported a suicide attempt.

- Most suicides involve firearms. In the United States, nearly three of every five suicides in 1997 (58%) were committed with a firearm. Other methods include poisoning (18%), strangulation (15%), and cutting (1%). Among 15- to 19-year-olds, 62% of the increase in the total number of suicides from 1980 to 1997 was due to the increase in firearm-related suicides. The availability of firearms in the homes of high-risk individuals markedly increases their risk for suicide.

- Some suicides are not reported. Medical examiners cannot always determine whether or not a person's death was deliberate. Even if suicide is suspected (for example, in the case of a self-inflicted gunshot wound or a one-car crash), the official cause of death may be listed as unintentional. Although such reporting may spare the family some emotional distress (or ensure that beneficiaries receive proceeds from life insurance), it results in the underreporting of suicides in the U.S.

Working toward a Solution

The need is great for suicide-prevention programs that target the groups at highest risk. Unfortunately, there is little evidence that such interventions are effective. But low and declining rates in some states and population groups offer hope that legislation and environmental and cultural changes can reduce the incidence of suicide nationwide. Examples of such changes are preventing inappropriate access to deadly methods such as drugs and firearms, improving family and community support, and teaching better coping skills.

- NCIPC collaborates with the Indian Health Service to support the American Indian/Alaskan Native Suicide Prevention Center and Network, which provides technical assistance for suicide-prevention activities for a variety of communities and operates a suicide-prevention program for teens.
- NCIPC organized and cosponsored (with public and private partners) the first National Suicide Prevention Conference, which brought together representatives from all 50 states to make recommendations for a national suicide-prevention strategy.
- NCIPC coauthored *The Surgeon General's Call to Action to Prevent Suicide*, which introduced a blueprint for addressing suicide, *Awareness, Intervention, and Methodology (AIM)*. AIM includes 15 key recommendations developed by conference participants and based on findings presented at the conference.
- To investigate risk factors for suicidal behavior, NCIPC conducted a case-control study of nearly lethal suicide attempts in regard to the roles of alcohol use and abuse, geographic mobility (moving frequently), and suicidal contagion (exposure to the suicidal behavior of friends and acquaintances and to portrayals of suicide in the media). Preliminary results indicate that alcohol use within 3 hours of an attempt and geographic mobility are important risk factors for suicidal behavior. Contrary to expectations, those exposed to suicidal contagion were less likely to make nearly lethal suicide attempts.

To determine the factors that contribute to suicidal behavior, NCIPC is funding the following research:

- Researchers at Emory University are working to identify risk factors for suicide among black adults. They are comparing blacks ages 18 to 44 who have attempted suicide with blacks in this age group who have not. The study will evaluate personal factors (skills, emotional state, and cognition) and environmental factors (social and economic status and stresses). Study results will aid in designing effective suicide-prevention programs for blacks.
- Children and teens who have unauthorized access to firearms at home may be at risk for suicide and unintentional injury. In Seattle, Washington, a study is underway to evaluate safe practices for firearm storage. To determine the best ways to reduce firearm-related injury and death among young people, researchers are compiling data on gun-storage boxes, safes, trigger locks, storing guns unloaded, and storing guns and ammunition in separate locations.
- NCIPC has awarded a planning grant for development of a suicide-prevention research center that will describe the magnitude of suicidal behavior, promote research, and identify prevention activities.

- NCIPC has funded two suicide-prevention evaluation projects. One targets high school students and is designed to enhance awareness and use of telephone crisis-intervention services for teenagers, as well as evaluate the project's efficacy. The second project, a life review, targets adults over the age of 65. The life review is a structured process of reminiscence, instigated by a therapeutic listener who helps individuals organize and synthesize their lives until the individuals accept life as they have lived it. Because the life review is a seemingly natural storytelling process with no stigma attached, it engages older people with minor depression who otherwise often refuse mental health services.
- The Harvard Injury Control Research Center is conducting a study on intentional injury among 6,000 Chicago youths. The study's goals include determining the prevalence of intentional injury and examining the relationship between such injury and related problems, such as medical treatment and psychiatric disorders. Study results will increase understanding of the risk factors for intentional injury, as well as its prevalence and consequences. Preliminary analyses have focused on aspects of suicide.



Christopher W., 18, had just graduated from high school and was planning to go to college when he killed himself. "He was my only child," his father said. "I was as proud of him as any father could be. He was a star student and athlete and was even an Eagle Scout. I was shocked to the very core of my soul when, without warning, he shot himself in the head. He left no note to say why he did it. It appeared to be an impulsive act that perhaps could have been prevented if he would have told anyone how he was feeling. He used a gun that was kept at a small business where he worked part-time."

INTIMATE PARTNER AND SEXUAL VIOLENCE

Intimate partner violence includes actual or threatened physical and/or sexual violence or psychological/emotional abuse directed toward an intimate partner. Many terms are used to describe intimate partner violence: domestic or spouse abuse, battering, domestic or courtship violence, marital and date rape. We use the term “intimate partner violence” because it includes all forms of violence that occur in any type of intimate relationship, whether it is between spouses, ex-spouses, current or former boyfriends and girlfriends, or current or former dating partners. Intimate partners may be heterosexual or of the same sex.

Sexual violence includes the use of physical force to compel a person to engage in a completed or attempted sexual act against his or her will. A completed or attempted sexual act without the presence of force is also considered a form of sexual violence if the victim cannot understand the nature or condition of the act or cannot communicate unwillingness to engage in the act because of age, illness, disability, the influence of alcohol or other drugs, intimidation, or pressure. Sexual violence may also include abusive sexual contact.

The Scope of the Problem

The FBI provides data on deaths perpetrated by intimate partners, but the full extent of nonfatal and fatal intimate partner violence in the United States is not known. Not all incidents are reported to police, but even when the incidents are reported, they may not be identified as intimate partner violence or recorded as such. Similarly, if victims need medical care, they may not disclose that their partner hurt them. Even if they do, the information may not be recorded in the medical record. Currently, standard systems are not in place to systematically record and count incidents of intimate partner violence in health care settings. Despite these gaps in information, we know that such violence affects a high proportion of the population. The full extent of sexual violence is not known either.

Like intimate partner violence, sexual violence often goes unreported because of embarrassment, denial, or fear of retaliation, especially when the perpetrator is someone known to the victim.



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- More women than men experience intimate partner violence. The National Violence Against Women (NVAW) survey found that 25% of surveyed women had been raped or physically assaulted by an intimate partner at some time in their lives. In contrast, only 8% of surveyed men reported such an experience.
- Intimate partner violence is a major cause of violence-related injuries. In 1994, more than 500,000 women visited a hospital emergency room for violence-related injuries. Current or former intimate partners inflicted 37% of the injuries. Overall, 84% of those treated in emergency departments for injuries inflicted by intimate partners were women.
- Intimate partner violence is more lethal for women than for men. FBI data show that in 1998, 32% of all female homicide victims were murdered by an intimate partner. In contrast, 4% of male murder victims were killed by wives, ex-wives, or girlfriends.
- Sexual violence affects many Americans. Data from the revised National Crime Victimization Survey (NCVS) for 1992-1993 indicate that 500,000 sexual assaults and rapes are reported annually.
- Women are the primary victims of sexual violence. In the NVAW survey, 18% of women reported being victims of a completed or attempted rape at some time in their lives, compared with 3% of the men surveyed.
- Most female victims of sexual violence knew their assailant before the attack. According to 1992-1993 NCVS data, women who reported being victims of sexual violence identified friends and acquaintances as the assailant in 56% of cases. Intimate partners were the assailant in another 26% of such cases.
- Sexual violence is a crime against the young. According to NVAW survey data, 54% of female rape victims were sexually assaulted before the age of 18. Women were more likely to report being raped as adults if they also reported being raped before age 18.
- Victims of sexual violence often sustain injuries other than the rape itself. For rapes perpetrated against an adult, 32% of female victims and 16% of male victims report injuries other than the rape.

- Intimate partner violence and child abuse are closely linked. Increased frequency of violence toward a spouse is associated with increased risk of the violent spouse (particularly a husband) also abusing their children.

Working toward a Solution

NCIPC sponsors research projects to monitor these issues, determine risk factors, and develop prevention programs.

- With the help of experts in family violence, NCIPC developed uniform definitions for intimate partner violence and recommended data elements for surveillance of such violence. NCIPC is also developing uniform definitions and recommended data elements for sexual violence. Surveillance systems for intimate partner violence have been funded for five state health departments (Kentucky, Massachusetts, Michigan, Oklahoma, and Rhode Island).
- NCIPC and the Department of Justice supported the NVAW survey, which provides estimated levels of intimate partner violence, sexual violence, and stalking.
- A study was conducted to identify individual risk and protective factors that affect the escalation as well as the end of violence.
- A case-control study was conducted to investigate the links between intimate partner violence and suicide attempts. There was a strong connection between such violence and suicidal behavior by black women. Additional funding has been provided to conduct a prospective study to develop interventions for suicidal, battered women to reduce the injuries and deaths associated with both intimate partner violence and suicide.



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Intervention programs are being evaluated for their effectiveness in reducing intimate partner violence. These include

- Treatment programs for batterers
- Media campaigns to raise community awareness
- Six coordinated community-response projects to develop and evaluate such responses and/or to improve and evaluate existing community-wide responses
- Eight community-based primary-prevention projects including dating violence prevention, an intervention project for child and adolescent witnesses of intimate partner violence, and community education
- A dating-violence prevention curriculum targeting eighth and ninth graders

NCIPC is addressing or has addressed professional training needs by

- Funding a recent Institute of Medicine report on the *Training Needs of Health Care Providers in Detecting Family, Intimate and Sexual Violence*
- Publishing a bibliography summarizing health-care-provider training programs and materials on intimate partner and sexual violence

- Providing support and technical assistance for a program that trains outreach health workers about intimate partner violence and develops resources for Mexican and Mexican-American migrant farm workers. This program has won the President's Award for Excellence and the Marshall Award, sponsored by Marshalls department stores
- Evaluating the domestic-violence module for second-year medical students at UCLA

The Violence Against Women (VAW) Prevention Research Center was funded by NCIPC in 1998. It will

- Disseminate prevention research
- Provide special outreach efforts to attract and train VAW researchers among racial and ethnic minorities
- Identify and overcome barriers to collaboration between researchers, victim advocates, and public health, criminal justice, and victim-services practitioners
- Foster interdisciplinary research on preventing VAW
- Review research literature on VAW
- Analyze data sets that emphasize VAW prevention
- Develop and pilot test new strategies for VAW prevention and intervention
- Provide training and technical assistance to researchers and practitioners
- Provide specialized training to researchers on key issues in VAW research and in writing competitive grant applications

To address the problem of sexual violence, NCIPC has been working in a number of areas:

- Providing technical assistance to public health departments and sexual assault coalitions in each state and territory and to designated Native American tribes
- Holding three regional meetings to stimulate statewide planning

- Planning a national conference for May 2000 to strengthen communication and working relationships on sexual violence issues among service providers, public and private organizations, advocates, and government
- Determining if there are campus sexual-assault policies for a national random sample of colleges
- Funding a National Sexual Violence Resource Center. The program will
 - ◆ Strengthen the support system for sexual-assault survivors
 - ◆ Provide leadership in preventing sexual violence
 - ◆ Provide comprehensive information and resources, policy analysis, and development
 - ◆ Enhance prevention of sexual violence and community response to such violence by providing technical assistance and professional consultation to sexual-assault programs; national, state and local organizations; community volunteers; and the media
- Johns Hopkins University is evaluating a program designed to improve the response of emergency department (ED) staff to battered women. The program consists of a training manual, model policies and procedures, resource materials, in-service education, and strategies that encourage ED staff to respond to the needs of battered women.
- An intervention program is being conducted at the University of Michigan to reduce the impact of domestic violence on women and children and to reduce the risk of repeated violence. The program will be evaluated in regard to its effectiveness and in regard to which mothers and children it benefits most. The program can then be improved and offered to other communities.
- The University of Pittsburgh is conducting a pilot project in primary care practices to test a screening protocol for intimate partner violence and a related referral network. Because victims of intimate partner violence can be identified and treated before they are hurt badly enough to have to go to an emergency department, primary care providers can intervene and offer appropriate referrals to such women. The screening tool used in this study allows physicians to identify victims of intimate partner violence. Physicians are provided with the information and training materials necessary to do the screening and to make referrals.

Highlights from NCIPC-funded research include the following studies:

- The University of Georgia is evaluating a program designed to prevent sexual assault from occurring among women who have already been victimized. The program, which includes training in problem-solving skills, assertiveness, and identifying personal risk factors, is expected to reduce the risk of revictimization and to be most effective for participants with a history of single versus multiple victimization.
- A study of men who batter their female partners, and of the female partners, is being conducted at Indiana University of Pennsylvania. The study is following the long-term results of four different “batterer” intervention systems and measuring the economic costs of each system. Study findings will help shape policy and program development in the rapidly growing field of batterer intervention.
- Dating violence is being studied by researchers at the University of North Carolina. They are examining, among other factors, the emotions that precipitate such violence, the intended outcome of dating violence versus the actual outcome, and peer group characteristics. Study results indicate that 1) predictors of dating violence differ for boys and girls; and 2) stress is associated with dating violence, and the type of stress associated with such violence varies by gender. These results suggest that gender-specific interventions may be needed to minimize exposure to stress and to maximize coping skills. Findings will contribute to the development of gender-appropriate interventions to prevent dating violence.

On Valentine's Day 12 years ago, Jane's ex-husband murdered their daughter and then killed himself. He had stalked and threatened to kill Jane many times after she took their children and left an increasingly abusive marriage. Today Jane still struggles to put the events of February 14 and the preceding years of violence behind her. "Even with professional help, flashbacks of abuse race through my mind," she says. "Nightmares soon follow, with seeing our beautiful daughter murdered by her father instead of me being murdered. This was his ultimate abuse, to prove that I should have listened to what he said."